Frequently Asked Questions

Prior Authorization

Who is HealthHelp?

HealthHelp is a specialty benefit management company that has partnered with Highmark Wholecare to administer a new collaborative and educational authorization program for **Outpatient Sleep, Radiation Oncology and Cardiology services effective 3/21/2022 and Diagnostic Imaging, Physical Medicine, Musculoskeletal/IPM effective 5/1/2024.**

What is HealthHelp's Program for Highmark Wholecare?

HealthHelp provides a collaborative and educational authorization program that improves quality and reduces the cost of care by providing expert peer consultation and the latest evidence-based medical criteria for managed procedures. The HealthHelp collaborative, educational authorization process involves collecting relevant clinical information from the ordering/treating provider's office, reviewing this information alongside current evidence-based guidelines, and if necessary, providing provider-to-provider consultation on treatment and/or test appropriateness and patient safety. If the requested service does not meet evidence-based guidelines, a HealthHelp specialist will have a provider-to-provider conversation with the requesting provider to consider alternatives.

What are the tests and procedures that would require a prior authorization within each specialty?

Effective 3/21/2022, ordering providers will be required to obtain authorization for the following outpatient procedures, except services rendered for emergency level of care:

- Sleep: Sleep Testing, PAP Therapy, Oral Appliances
- Radiation Oncology: 2D3D, Brachytherapy, Stereotactic, Proton Beam, IMRT, IGRT
- Cardiology: Peripheral Revascularization, Cardiac Devices, Ablation/EPS

Effective 5/1/2024, ordering providers will be required to obtain authorization for the following outpatient procedures, except services rendered for emergency level of care:

- Diagnostic Imaging
- Musculoskeletal (MSK)/IPM: Shoulder, Hip, Knee, Spine, and Interventional Pain Management of the Spine
- Cardiology: Required for all members, regardless of age
- Physical Medicine: Physical Therapy, Speech Language Pathology, and Occupational Therapy

Where can I find a complete list of procedure codes requiring authorization?

A complete list of procedure codes requiring authorization can be found at www.healthhelp.com/HighmarkWholecare.

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What LOB/Membership will be impacted by this new prior authorization program?

HealthHelp's managed programs are applicable to both Medicare and Medicaid Lines of Business. The Pediatric Population (<18 years old) will be serviced for Cardiology, Diagnostic Imaging, Physical Medicine, and Musculoskeletal programs. Sleep and Radiation Oncology will not service the <18 population.

How will authorization requests be submitted between now and 5/1/2024 when the HealthHelp process goes live with new programs?

Requests requiring prior authorization for new services will begin on 5/1/2024 for services being delivered. If you have a patient already under treatment, any MSK/IPM, Physical Medicine, Diagnostic Imaging services being rendered as of 5/1/2024 will require a prior authorization number for approval, if an authorization has not already been obtained. As of date of service 5/1/2024, MSK/IPM, Physical Medicine, Diagnostic Imaging services being rendered to a new or existing patient will require a prior authorization number for approval and reimbursement to occur.

Is an authorization required for all identified tests and procedures?

Yes, an authorization is required to ensure successful processing of your claim's payment. All tests and Outpatient procedures identified in the managed code lists will require authorizations through the HealthHelp process beginning 3/21/2022 for Cardiology, Sleep, and Radiation Therapy and 5/1/2024 for MSK/IPM, Physical Medicine, Diagnostic Imaging services.

How can I obtain a login to request authorizations or check status online?

All new requests for access to HealthHelp's online authorization request system must be submitted through the enrollment form posted to www.healthhelp.com/HighmarkWholecare. New online accounts are typically created within 24 business hours from receipt of the completed enrollment form.

What if I already use HealthHelp to request prior authorizations from another health plan?

If you already have online access to the HealthHelp system through another health plan, please contact HealthHelp's program support to request that Highmark Wholecare be added to your existing access and provide your current User ID (RCSupport@HealthHelp.com or call (800) 546-7092). Also, if you submit requests on behalf of Highmark Wholecare ordering providers, you will need to provide the full name of all Highmark Wholecare providers that you will be placing requests for.

Note: Though your HealthHelp online user account may be created prior to program go live, authorization requests will not be accepted through the HealthHelp process until 5/1/2024 for expanded programs.

Is prior authorization necessary if Highmark Wholecare is NOT the member's primary insurance?

Yes, this program applies when members have Highmark Wholecare as the primary or secondary insurer.

Will procedure codes used to evaluate a member require prior authorization?

Initial Physical Medicine (PT, OT, SLP) evaluation codes do not require authorization.

How can providers request a prior authorization number for services?

Ordering providers can request an authorization for managed services using one of the following three methods:

- Internet/web: www.healthhelp.com/HighmarkWholecare
- Expedited Request Fax: 877-637-6935
- Phone: 888-265-0072

HealthHelp representatives are available from 8:00 AM to 6:00 PM Eastern Time, Monday through Friday. The website is available 7 days a week, 24 hours a day.

What information is needed to initiate a prior authorization request?

The following information is required for all authorization requests and should be available in the patient's chart:

- Member name and ID number
- Ordering provider name
- Ordering provider telephone and fax numbers
- Member diagnosis or clinical indication
- Test being ordered (Procedure code)
- Reason for test
- Member symptoms and duration
- Prior related diagnostic tests
- Laboratory studies
- Member medications and duration
- Prior treatments
- Summary of clinical findings
- Member risk factors

Can a provider request more than one procedure at a time for a member?

Providers will have the ability to submit multiple procedure requests for the same member for some programs. After the first procedure is built, the user is asked if another procedure request needs to be submitted. If yes, they are "batched" or linked together by a unique Batch ID with a separate Tran ID (short for Transaction ID) assigned to each additional procedure submitted. In a multi-procedure case, each Tran ID is evaluated separately for appropriateness/medical necessity. Multiple procedure requests are not available for the Physical Medicine programs (PT, OT, SLP). A separate request must be created for additional procedures. The system will **not** confirm if another procedure needs to be submitted.

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How long does the authorization decision process take?

Assuming appropriate criteria has been met and the necessary information (as outlined previously) is provided, prior authorization requests can be completed in minutes. If the prior authorization request is submitted via phone or fax, HealthHelp will submit a confirmation fax to the fax number collected during the prior authorization request process. If the request for a prior authorization is submitted online, the provider office may immediately print the confirmation sheet within the online tool.

Should a procedure need clinical or peer review, prior authorization can take up to 48 hours at each step (e.g. review with a nurse or physician reviewer). For complicated cases, this time period may be extended. For cases subject to clinical or peer review, a fax submission is responded to immediately via a fax to the ordering provider's office. Requests submitted online will indicate that a referral to clinical review has been made; clinical information must be uploaded.

- Please include the following when uploading:
    - Last two office visit notes
    - Recent diagnostic testing (Include the reports)
    - Recent conservative therapies such as prescription and non-prescription medication, physical therapy or prescribed rest
    - List comorbidities, if any and for how long
    - Case-specific information
        - For Cardiology cases please include the most recent EKG report
        - For Sleep study please include any reports from any recent in-home or in-lab sleeps studies
- The HealthHelp Nurse reviewer will contact you. Please make sure your contact information is correct and up-to-date and included with this information.

Can I check to see if a prior authorization has already been obtained for a member?

Yes. When you are logged into the HealthHelp's WebConsult website click the "Request Status" link at the top of the page or access WebStatus directly at https://portal.healthhelp.com/WebStatus .
A provider may search for a request by entering the member's name, date of birth and/or member number for any 90-day date range based on the date of request. You may also view request by provider or rendering facilities. To obtain access to WebStatus or add providers or rendering facilities to your profile please contact Program Support at rcsupport@healthhelp.com or phone: 1-800-546-7092. You may also check the status of a prior authorization by calling HealthHelp's inbound call center at 888-265-0072

How can my staff get additional training or support?

HealthHelp provides training throughout the course of our business relationship with Highmark Wholecare. We work closely with the provider network to train providers and office staff on the procedures used for acquiring proper prior authorizations. Webinar schedules will be available at www.healthhelp.com/HighmarkWholecare

To request more information on this program or request additional training, please contact:

Program Support
HealthHelp
rcsupport@healthhelp.com
Phone: 1-800-546-7092

Can multiple providers render services to members if their name is not on the authorization?

Yes, the authorization is linked between the members ID number and the facility's tax ID and NPI. So if the provider works under the same tax ID and are of the same discipline, they can use the same authorization to treat the member.

If the servicing provider fails to obtain prior authorization for the procedure, will the member be held responsible?

Members do not have any additional financial responsibility, assuming use of a participating provider, regardless of whether the provider obtains prior authorization for the procedure or not. The participating provider may be unable to obtain reimbursement if prior authorization is not obtained; however, members do not have financial responsibility above their plan benefit determinations. authorization.

If a provider has already obtained prior authorization and more visits are needed beyond what the initial auth contained, does the provider have to obtain a new prior authorization?

If additional services are needed, the provider should submit another/separate request. Once a request has already been authorized HealthHelp does not have the ability to add to a request.

What if I just need more time to use the services previously authorized?

The provider should submit another/separate request for all procedures other than Physical Medicine. Once a request has already been authorized HealthHelp does not have the ability to extend timing for that authorization.

For Physical Medicine, an option is available in HealthHelp's online authorization request system to request an extension, up to an additional 30 days from the end date of the approved authorization. You can also contact customer support for an extension.

What will the authorization number look like?

QR + VanID. VanID being a unique 8-digit number
Example: QR10002386

How long is the prior authorization number valid?

- Sleep Study: 90 Days
  - Sleep DME: 90 Days (initial treatment), 300 Days (continuation of treatment)
- Radiation Oncology: 90 Days
- Cardiology: 90 Days
- MSK/IPM: 90 Days
- Physical Medicine: 60 Days
- Diagnostic Imaging: 90 Days

If a provider obtains a prior authorization number does that guarantee payment?

An authorization number is not a guarantee of payment. Authorizations are based on medical necessity and are contingent upon eligibility and benefits. Benefits may be subject to limitations and/or qualifications and will be determined when the claim is received for processing.

Does HealthHelp allow retro-authorizations?

In order to assure that Clinical Operations receives notification of cases requiring authorization in a timely manner, providers requiring authorization of services should request such authorization before the service is provided, but no later than one (1) business day after the service begins. For Inpatient Admissions, retro request must be received by the 4th business day following admission.

How will inpatient care be handled?

HealthHelp will make a determination and if approved, will send the requesting provider an authorization confirmation for that provider, site of service, and procedure only. The inpatient level of care evaluation and determination will be provided by Highmark Wholecare. There are no additional actions needed by the provider at this time.

How is medical necessity defined?

For Medicaid:
A service or benefit that is compensable under the MA Program and if it meets any one of the following standards:

1. The service, item, procedure or level of care will, or is reasonably expected to, prevent the onset of an illness, condition, injury or disability.

2. The service, item, procedure or level of care will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.

3. The service, item, procedure or level of care will assist the Member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for Members of the same age.

For Medicare:
Medically necessary means that the services, supplies or drugs are needed for the prevention, diagnosis or treatment of your medical condition and meet accepted standards of medical practice.

HealthHelp is a separate company that offers education and guidance from specialists in sleep, cardiology, and radiation oncology, MSK/IPM, Diagnostic Imaging, and Physical Medicine for Highmark Wholecare.

Health benefits or health benefit administration may be provided by or through Highmark Wholecare, coverage by Gateway Health Plan, an independent licensee of the Blue Cross Blue Shield Association (“Highmark Wholecare”).